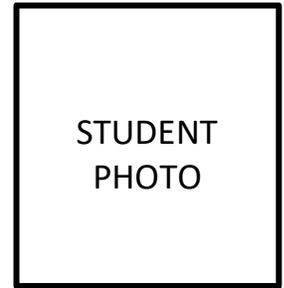




Anchorage School District SEIZURE ACTION PLAN



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

SEIZURE TRIGGERS OR WARNING SIGNS

- Stress Intense emotions Boredom Lack of sleep
 Fever Television, videos, or flashing lights Other: _____

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION
<input type="checkbox"/> Absence seizures (petite-mal)			A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.
<input type="checkbox"/> Tonic-clonic or convulsive seizures (grand-mal)			The student will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities will then jerk and twitch rhythmically (clonic phase). Student may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
<input type="checkbox"/> Myoclonic seizures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.
<input type="checkbox"/>			

STUDENT'S RESPONSE AFTER A SEIZURE: _____

MEDICAL PROVIDER AUTHORIZATION

BASIC SEIZURE FIRST AID	SEIZURE EMERGENCY PROTOCOL
<ul style="list-style-type: none"> Stay calm and track time Keep the student safe Do not restrain the student Do not put anything in the student's mouth Stay with the student until they are fully conscious Document the seizure occurrence <div style="text-align: center; font-weight: bold; margin: 5px 0;">For a tonic-clonic or convulsive seizure</div> <ul style="list-style-type: none"> Protect the student's head Keep airway open Watch breathing Turn child on their side 	<p>If student has a tonic-clonic or convulsive seizure lasting longer than 5 minutes, repeated seizures without regaining consciousness, is injured, has diabetes, has breathing difficulties, or the seizure occurs in the water...</p> <ul style="list-style-type: none"> CALL 911 and ADMINISTER EMERGENCY MEDICATION AS PRESCRIBED.

MEDICATION	USE	DOSE	ROUTE
<input type="checkbox"/> Diazepam (Diastat)	For seizures lasting _____ minutes or longer.		Rectal
<input type="checkbox"/> Midazolam	For seizures lasting _____ minutes or longer.		<input type="checkbox"/> Buccal <input type="checkbox"/> Intranasal
<input type="checkbox"/>			

- YES NO **Does this student have a vagal nerve stimulator (VNS)?**
 Please describe use: _____
- YES NO **Is this student allowed to participate in usual school activities including physical education?**
- YES NO **Does this student require any special considerations or safety precautions?**
 Please explain: _____

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE



Anchorage School District
SEIZURE ACTION PLAN

PARENT / GUARDIAN AUTHORIZATION

I request that the medication selected and seizure protocols listed on this plan be provided to my child. I agree to defend and hold school district employees harmless from any liability for the results of the medication, or the manner in which it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I understand that this medication will be destroyed at the end of the school year, per DEA federal requirements, unless I pick up the remaining medication by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER

Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

NURSE PLAN REVIEW

I have reviewed the *Seizure Action Plan* for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE